

Bolton Wheelchair Service Referral Form

This form is to be completed by a registered health or social care professional. Please ensure you have read our eligibility criteria, which can be found on our website or requested using the contact details below.

Please complete the form in full. Mandatory fields are marked in red. Incomplete forms may be returned to you and may cause delays. This form is designed for completion on-screen. We recommend using Adobe Acrobat software.

For assistance with this form, please call the wheelchair service on 01204 322 862. When complete, please return your referral form using a secure email service to ajm.bolton-wheelchairservice@nhs.net

01. Prioritisation Information

Is the service user receiving palliative care?	Yes	No	Discharge date:
Are there current grade 3/4 pressure injuries?	Yes	No	Discharging from hospital/ward:
Is this referral required for hospital discharge?	Yes	No	Discharging to:

02. Service User Details

Title:		Does the service user have capacity?	Yes	No	
Forename(s):		If no, who will act in their best interests?			
Surname:		Relationship:			
Telephone/mobile:		Telephone/mobile:			
Email:		Email:			
Address, including postcode:		Address, including postcode:			
Are there any risks to staff visiting the address?	Yes	No	Is this person a "Looked After Child"?	Yes	No
If yes, details:			If yes, details/funding:		
Date of birth:			Is this person CHC or CC funded?	Yes	No
NHS Number:			If yes, details/funding:		
Any religion/belief:			Is this person a prisoner?	Yes	No
Ethnicity:			If yes, details/funding:		
Communication needs:					

03. GP Details

GP Name:	Address, including postcode:
Telephone:	
Email:	

04. Reason for Referral

Option 1. Please assess this person.

They require:

Option 2. This person is an existing wheelchair service user. Please review their existing provision.

The main reason for review is:

Option 3. Please assess this person for a powered wheelchair. I confirm I have read the eligibility criteria for powered wheelchair provision.

They require:

Can they safely and effectively self-propel a manual wheelchair indoors? Yes No

Do they have any visual impairments which would affect their ability to safely drive a powered wheelchair? Yes No

Do they have any cognitive or visuo-spatial issues, or suffer from hearing impairment, epilepsy or any other conditions which can cause loss of consciousness? Yes No

If you have answered yes to any of these questions, please provide details in the space below.

Please provide any further details about your reason for referring this person here:

05. Existing Care Arrangements

Formal carers

Service name:

Frequency of care:

Contact details:

Contact name:

Occupational Therapy

Service name:

Contact details:

Contact name:

Physiotherapy

Service name:

Contact details:

Contact name:

Education/Work

Service name:

Contact details:

Contact name:

Informal carers

Name/details:

Frequency of care:

Contact details:

Contact name:

Social care

Service name:

Contact details:

Contact name:

Speech and Language Therapy

Service name:

Contact details:

Contact name:

Any other relevant organisation

Service name:

Contact details:

Contact name:

06. Medical Details

Height:	Can the person self-propel?	Yes	No
Weight:	Is there a recent history of falls?	Yes	No
Diagnosis / medical condition / reason for referral:	Is this person considered to have a terminal illness (i.e. <6 months)?	Yes	No
	Are they known to a palliative care team or do they have a DS1500 (or equivalent) form?	Yes	No

What is their mobility status?

How long are they able to maintain a sitting balance unaided?

How often will the wheelchair be used?

How long will they be seated in the chair each day?

Where will the wheelchair be used most often?

How do they transfer / what is their transfer ability?

What wheelchair do they currently use, if any?

What cushion/seating system do they currently use, if any?

Hip width:

- The width of the widest part of the hip
- Ensure that the tape measure does not bend when measuring

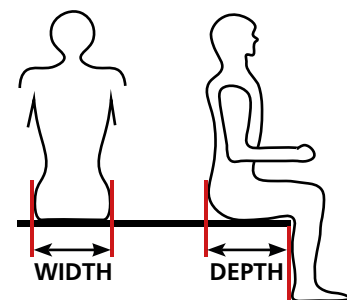
Seat depth:

- From the back of the knees to the rear-most part of the bottom

Knee to heel length:

- From the back of the knee to the floor, under the heel

Measurement Guide



Are there any considerations for seating provision? For completion by medical professionals. Please leave blank if unknown.

Specialist controls may be required	Contractures preventing normal sitting	Hip	Knee	Ankle
Use of PEG feeding tube	Scoliosis	Mild	Moderate	Severe
Augmentative/Alternative Communication (AAC) needs	Kyphosis	Mild	Moderate	Severe
Use of ventilator or oxygen	Pelvic obliquity	Mild	Moderate	Severe
Continence issues with bladder	Spasticity	Mild	Moderate	Severe
Continence issues with bowels	Increased tone	Mild	Moderate	Severe
Use of a catheter	Decreased tone	Mild	Moderate	Severe
Use of a suprapubic catheter	Increased foot deformity	Mild	Moderate	Severe
Use of incontinence products, e.g. absorbent pads				

Please provide any additional details about the person or their needs. If none, please state "n/a".

07. Home Environment

Are there currently any potential issues with using a wheelchair in the home environment? If yes, please select the options that apply below.

Yes No

Steps into property	Bathroom access	Front door width:
Narrow doorways	Lack of storage space	Narrowest door width:
Tight turns	No charging location	Hallway width/turns:
Multiple floors, no lift	Multiple floors, with lift	

Is it likely that home adaptations will be required?

08. Pressure Ulcer Risk Assessment

Location and grade of previous pressure ulcers:

Are there risk factors which would indicate a requirement for pressure management, e.g. sitting posture, transfer technique, duration of sitting, etc.? If no, state "n/a".

Assessment Option 1 - Braden Scale for Predicting Pressure Sore Risk

Users with existing or previous pressure damage are immediately high risk. To be used in conjunction with clinical judgement. Select the appropriate option from each dropdown and then add the scores. Lower scores indicate a higher risk.

Sensory perception - ability to respond meaningfully to pressure related discomfort:

Mobility - ability to change and control body position:

Moisture - degree to which skin is exposed to moisture:

Activity - degree of physical activity:

Nutrition - usual food intake:

Friction and shear:

Total score:

Assessment Option 2 - Waterlow Pressure Sore Risk Assessment Tool

Select the appropriate option from the tickboxes and then add the scores. More than one score/category can be used.

Build/weight for height Average BMI 20–24.9 0 Above Average BMI 25–29.9 1 Obese BMI > 30 2 Below Average BMI < 30 3	Skin type visual risk areas Healthy 0 Tissue Paper 1 Dry 1 Oedematous 1 Clammy, pyrexia 1 Discoloured, grade 1 2 Broken spots, grade 2–4 3	Sex and Age Male 1 Female 2 14–49 1 50–64 2 65–74 3 75–80 4 81+ 5	Malnutrition Screening Tool (MST) A. Has the patient lost weight recently? If yes, complete B below. If no, complete C below. If unsure, go to C and add 2. C. Is the user eating poorly or lacking appetite? No 0 Yes 1 Nutrition Vol. 15, No. 6, 1999 Australia	B. Weight Loss Score 0.5–5 KG 1 5–10 KG 2 10–15 KG 3 > 15 KG 4 Unsure 2
Mobility Fully 0 Restless/fidgety 1 Apathetic 2 Restricted 3 Bedbound, e.g. traction 4 Chairbound, e.g. wheelchair 5	Continence Complete or catheterised 0 Urinary incontinence 1 Faecal incontinence 2 Urinary and faecal incontinence 3	Special Risks Tissue Malnutrition Terminal cachexia 0 Multiple organ failure 1 Single organ failure 2 Peripheral vascular disease 3 Anaemia (Hb < 8) 4 Smoking 5	Neurological Deficit Diabetes, MS, CVA 4–6 Motor / sensory 4–6 Paraplegia (max of 6) 4–6 Major Surgery or Trauma On table >2 hrs* 5 On table >6 hrs* 8 Orthopaedic / spinal 5	Total Score: Score Key: 10+ = at risk 15+ = high risk 20+ = very high risk
* Scores can be discounted after 48 hours provided the patient is recovering normally. Reproduced from www.judy-waterlow.co.uk				Medication - cytotoxics, long term or high dose steroids, anti-inflammatories 0–4

09. Referrer Details

Name:

Email:

Profession / role:

Telephone:

Address:

Accreditation number:

I have obtained this person's consent for this referral:

OR I am acting in this person's best interests by referring:

Signature:

If completing on-screen, please write your name in this box and send from your personal email.

I would like to be invited to any appointments made:

Date:

Thank you for completing the referral form. If you would like to provide feedback on this form, or any other aspect of the wheelchair service, please email ajm.bolton-wheelchairservice@nhs.net. Your feedback is important to us.